Mass General Brigham
Health Plan

Jakafi (ruxolitinib)
Effective 02/01/2024

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693 **Non-Specialty Medications** All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview

FDA Approved Indications:

1. **Myelofibrosis** Indicated for treatment of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis in adults.
2. **Polycythemia Vera** Indicated for treatment of polycythemia vera (PV) in adults who have had an inadequate response to or are intolerant of hydroxyurea.
3. **Acute Graft Versus Host Disease** Indicated for treatment of steroid-refractory acute graft-versus-host disease (GVHD) in adult and pediatric patients 12 years and older.
4. **Chronic Graft Versus Host Disease** Indicated for treatment of chronic graft-versus-host disease (cGVHD) after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older.

Coverage Guidelines

Authorization may be granted for members new to the plan who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted when the following diagnosis-specific criteria is met:

Polycythemia Vera

1. Member has a diagnosis of polycythemia vera.
2. Member has had a trial and failure, contraindication, or intolerance to hydroxyurea.

Acute Graft Versus Host Disease

1. Member has a diagnosis of acute graft-versus-host disease.
2. Member's disease is steroid refractory.
3. Member is 12 years of age or older.

Chronic Graft Versus Host Disease

1. Member has a diagnosis of chronic graft-versus-host disease.
2. Member is 12 years of age or older.
3. Member with trial and failure of at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.)

All oncology criteria will be reviewed against Oncology Medication Review - NCCN guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B.

Continuation of Therapy

Polycythemia Vera

Authorizations may be granted when documentation of positive clinical response to Jakafi therapy (e.g., spleen volume reduction, symptom involvement, hematocrit control) is submitted.

Chronic Graft Versus Host Disease

Authorizations may be granted when the member does not show evidence of progressive disease while on therapy.

Limitations

1. For acute graft-versus-host disease: Initial approvals will be granted for 6 months.
2. For polycythemia vera: Initial approvals will be granted for 8 months.
3. For chronic graft-versus-host disease: Initial approvals will be granted for 12 months.
4. Reauthorizations will be granted for 12 months.

References

1. Jakafi Prescribing Information. Incyte Corp. Wilmington, DE. January 2023.

Review History

12/13/2023: Reviewed at Dec P&T. Effective 2/1/2024